EVOLUTION OF FEDERAL POLICY ON ACCESS TO HEALTH CARE 1965 TO 1980*

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I want to speak in very personal terms about what I know of the period from 1965 to 1980 to describe what I believe was happening and to draw some conclusions. In some measure, to borrow Dean Acheson's phrase, I was present at the creation. To many who till the fields of health care the creation seems to have occurred when Medicare and Medicaid were passed in 1965. After their enactment, we organized or attended a host of conferences, including one here at the Academy, presaging a grand future for those of us who believed that a new day had dawned in this struggle for equitable access to care. But I want to be a little personally reflective for reasons other than my presence at the creation. I have now had the great advantage of having been absent from the federal scene, that Garden of Eden, since the end of 1970. I must confess that the federal government world appears much different from an external perspective.

The title of my talk rests upon certain assumptions or facts. We assume that there really was a federal policy and that there continued to be a policy, otherwise, "why evolution?" We assume some critical character or critical nature to the facts of 1965 and 1980. "Evolution" carries some concept of progress, some concept of forward movement. But the year 1965 was perhaps not so critical

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when one takes a truly long-term look at the evolution of federal health policy for access to care. In a sense, 1965 was only another milestone on a highway that goes back many years because the programs of 1965 were built upon prior public policies whose beginnings can be found long before World War I.

By public policy I mean a course or intended course of action, deliberately adopted, after a review of a number of options and alternatives, which, coupled with appropriate means, is to be carried out. Such a concept of policy carries a strong implication about rationality and about analysis. While policy is obviously to a substantial extent rational, as I think back to the period of 1965 to 1970 I am impressed with how strong the forces of personality were. The forces of political personality were crucial in the making of federal policy in 1965. Rational analysis had its place, but it did not cover the field. Personality and the whim of the moment often gave policy its final shape.

It is fair enough for our purpose to think of 1965 as the point during the 1960s that brought to fruition a major collection of federal policies that had been in the works for many years. With the Social Security Act in 1935, clearly the federal government had embarked on social insurance programs that would include in time the substantive area of health. Prior to 1935, the federal government had limited its support to narrowly targeted medical care for veterans, merchant seamen, and soldiers and sailors, and, in general, for activities which we embrace under the field of quarantine or communicable disease. With the Social Security Act, the federal government, while retaining a focus on specialized problems, entered into a broader area of health care by providing in Title V and VI for grants to support maternal and child health programs and to support public health departments. During World War II we also had emergency programs for mothers and children.

After the war, with the growing economic strength of the country and with the boundless faith in science epitomized by Vannevar Bush's book, *Science: The Endless Frontier*,[1] we embarked on a set of federal programs to develop health resources. These included the development of facilities and equipment through the Hill-Burton Act in 1946 and the continued support and steady expansion of biomedical research and research training under the direction of the National Institutes of health, which itself had originated with the National Cancer Institute in 1937. Finally, federal policy evolved to cover health manpower, beginning with the support of clinical training of psychiatrists at the National Institute of Mental Health in 1948, other traineeships in the mid-1950s, and culminating in broad support under the general health professional educational assistance acts.

This led to the ferment during the middle 1960s when the federal government

began to move from the idea of simply developing resources and focussing on specialized problems to other broad areas. One was financial assistance to consumers, in this case, in 1965, for the elderly through Medicare and for the poor through Medicaid. The second was the organization and delivery of health care. Here government programs were typified by such legislation as the community mental health centers and mental retardation acts, the children and youth comprehensive projects, the maternity and infant care projects, the neighborhood health centers under the Office of Economic Opportunity and the Public Health Service, the Regional Medical Programs for heart, cancer, and stroke, and the comprehensive health planning program. A National Center for Health Services Research and Development also came into being. Simultaneously, in such other health related fields as air and water pollution or vocational rehabilitation, federal policy was emerging under appropriate legislation. In summary, one could regard the mid- and later 1960s as a period when much federal legislation was designed to deal with access to health care.

I would like to suggest one basic thought, namely, that a genuine social concern had evolved that it is unconscionable for people to be deprived of medical and health care because they have inadequate means or because they happen to reside in the wrong geographic place, either in the city or in the sparsely settled rural areas. Fundamentally, the agenda of the 1960s was one of equity, the achievement of which is a basic task of government. Clearly, this approach cost money, but the country was experiencing such economic growth and optimism that cost was a secondary consideration.

How should one describe the policy position in 1980? My own description would be of total government paralysis with respect to the formation of government health policy on any front other than cost control. Although President Carter's 1981 budget still claimed that access to care was our number one goal in health policy, the position in truth had been reached that there could be no action with respect to access to care until we had learned to control health care costs. We had moved in 15 years from total absorption in relieving the lack of adequate access to care to a position where we could not move on access until we knew how to control the cost of that access. We did not say so, but what we really meant was that we required an incomes policy applicable to those who provided the access.

What was happening on the policy front in the intervening years? First, the legislative process marched merrily along, producing new legislation. Might we have foretold in 1965 what the policy posture in 1980 would look like? Several intervening events show that it *was* foretold. In the preview of the budgets after

enactment of Medicare and Medicaid, a series of papers were prepared in the Bureau of the Budget for review by executive branch officials that predicted that an eventual cost explosion would follow creation of effective demand.

After President Truman lost his famous battle with the American Medical Association, the Public Health Service left the field strictly to the nonmedical personnel in the federal bureaucracy, especially the valiant staff in the Social Security Administration. The Public Health Service played a distinctly secondary role in the eventual implementation of Medicare/Medicaid. During the 1960s, following the passage of Medicare and Medicaid, the federal emphasis was to eliminate the financial barrier to access to care. At the same time, some efforts were beginning on the organization and delivery front. They first occurred in a leadership and demonstration role in the Office of Economic Opportunity, in which the Public Health Service had the least degree of interest. Then, after some interest in actual delivery grew in the Public Health Service, it became involved in the neighborhood health center movement. The Partnership for Health Act of 1965 thus included some provision for the organization of such services under the aegis of the Public Health Service.

At this point it is useful to remember that if the emphasis in the government in 1965 was on passage of Medicare and Medicaid, the emphasis of two special interests were on other legislation. The American Medical Association awoke very late to the impending passage of regional medical programs for heart, cancer, and stroke. The American Medical Association withdrew its opposition to Medicare in exchange for fundamental amendments to the regional medical program that made this program no threat to the organization and practice of medicine. The famous comprehensive health planning legislation, which grew out of the concerns of state health departments about the growth of American medical schools and academic medical centers, was introduced and passed very hastily after only one day of hearings before Congressman Rogers, hardly enough time for anyone to be quite sure about the purpose of the law. One thing it was intended to do, however, was to insert physicians of the Public Health Service into the organization and delivery of health services, a role which they had eschewed for many, many years.

If the seeds of 1980 were already present in 1965, is it possible to find some intervening points which show that the seeds were already beginning to grow? I want to discuss three particular periods: one is the 1971 plan of President Nixon, the second is the 1974 Nixon budget, and the third is the 1977 Ford budget. The three events together describe a very clear continuity of concern and policy evolution which shows that the eventual paralysis of 1980, which President

Reagan was willing to break away from, had its forerunners in the period of the 1970s.

The historical antecedents to 1980 and the budgets submitted by President Reagan are found in 1969 and 1970, when the Nixon Administration demonstrated that its domestic policies were based upon three major propositions. First, to control inflation and to reverse the deterioration of the nation's position in world economic affairs, fiscal policy had to be coupled with monetary policies and the balance of payments. Second in the Nixon policies was New Federalism, a phase described by many of Nixon's adherents as the heart of his policies. New Federalism itself had three primary subthemes: to clarify the roles of the federal government and the states, with the federal government responsible for income support and the states responsible for delivery of services; to improve the capacity of states through block grants and better management; and to reorganize and to improve federal structure and grants management. Because one task of the federal government was to use its tax powers to provide revenue to its partners, general and special revenue sharing developed. The third Nixon proposition was itself a policy of income maintenance, reflected eventually in the Family Assistance Plan that placed increased reliance upon the knowledge and the freedom of an individual to spend his income in the market place.

Nixon's 1971 Health Message defined the federal task in the national health strategy as provision of access to the health care system. To carry out this task, the Nixon Administration especially proposed the health maintainance organization technique, educational supports, and a national health insurance partnership in which all employers would be required to offer a minimum package of health insurance benefits. The federal government would create a family health insurance plan to replace Medicaid and to cover the working poor and would combine parts A and B of Medicare. Some of us who dream of a continued debate on national health insurance now think this was not so bad a plan.

Nixon's 1974 budget came to center stage on the domestic scene in an atmosphere of drama and emergency, accompanied by a clash of wills between the president and the Congress. Nixon had given ample warning during his 1972 re-election campaign of the size and shape of his next budget and of the policies of his next administration, and he was true to this warning. In health he proposed to end hospital construction grants, regional medical and community mental health programs, to phase out biomedical research grants, substantial withdrawal of federal support of medical and other health manpower activities, and major savings in Medicare and Medicaid requirements by shifting costs to their recipients. In all, Nixon proposed to cut back or to terminate 100 human resources

programs that he said did not work, were no longer needed, or were inconsistent with his three-fold philosophy outlined in his 1971 Health message. In addition, with prescient anticipation of 1981, he proposed not only special revenue sharing but also broad purpose grants to states in four areas: education, manpower, urban community development, and law enforcement.

Although health was not included in the special revenue sharing proposal of the 1974 budget, at the same time the Department of Health, Education and Welfare was preparing a major $500 million health revenue sharing proposal to move federal health functions to the states. What was especially new in the entire evolution of federal policies, so far as relations between Congress and the president were concerned, was the president's announced threat to impound funds if the Congress would not actually follow through on his proposals.

If the soothsayers were not foretelling 1981 in the 1974 Nixon budget, they surely were in Ford's 1977 budget. By 1976 it was clear that federal budget was being mortgaged by the rising cost of federal health programs. And yet, less than six years before submission of Ford's 1977 budget, Secretary Finch's Task Force on Medicaid, headed by Walter McNerney, had reported its disagreement with "the growing tendency to become excessively preoccupied with cost at the expense of community goals. The Task Force, along with what is possibly a majority in the health profession and certainly a majority of the population, interprets the recent federal enactments as intending that access to basic medical care shall be a right or entitleness of all citizens." Although this growing tendency toward preoccupation with rising costs had led, in the Task Force's words, to the point where "the promise of Medicaid that some care, at least, would be available to all who needed it has vanished into the obscurity of State determinations of eligibility and the limitations of State resources and priorities," the Task Force had few serious prescriptions for dealing with the preoccupation over rising costs.

And so, from the mid-1970s on, despite the rhetoric, genuine substantive concern about access had vanished from federal policy. Most of the policy considerations known as the Reagan budget were in place in Ford's 1977 budget, block grants for Medicaid and patient cost sharing for Medicare being only examples. From there on "the politics of frugality" dominated the American political scene, federal and state. New Congressional review procedures underscored the necessity to control medical care prices if new federal initiatives were to be budgetarily feasible.

President Ford's 1977 budget message was only four pages long. The debate between the president and the Congress was not really about amounts but about

trends, relative levels, and choices to be made between military programs and social programs. Ford proposed major reductions in all human resource programs. It is worth remembering that he proposed four block grants for 59 programs in health, education, social services, and child nutrition, and he proposed the Financial Assistance Health Care Act as a $10 billion health care block grant, to include Medicaid and 15 categorical project and formula health grants.

Ford's 1977 philosophy had three very clear points. First, the federal sector had expanded too greatly and had to be slowed down. Two, the built-in cost escalation of many entitlement programs, in those days still called benefit programs, had to be halted. And three, federal grants were too complex and numerous. They had to be consolidated.

By 1980, when Carter submitted his 1981 budget, federal health policy had become very simple: reliance on preventive care and upon efficiency and effectiveness to assure that all health services should be both reasonable in cost and safe. President Carter's national health plan was stated to be the cornerstone of the Administration's health strategy to insure universal access to health insurance coverage and to overcome financial and geographical barriers. However, the real cornerstone of the Administration's health care strategy was the hospital cost-containment plan that totally failed of enactment by the Congress and was opposed by practically every health care interest.

It has to be admitted that all during this period, because of the way in which the Congress operates and the way in which the American political system works, we did continue in a variety of individual programs to expand services to the poor and to the underserved. For example, we organized the National Health Service Corps, started new family health centers, introduced the urban and rural health initiatives, expanded migrant health programs, enlarged Indian health services, extended the Medicare program to cover rural health services under the rural clinics act, and continued to maintain the community mental health centers program. There was even a brief effort under Carter to make mental health services more widely accessible. Nevertheless, the clear picture is that at the start of the 15-year period there was a genuinely ebullient hope for the future, and at the end of the period we see despair and, in fact, a form of policy paralysis.

Naturally, one asks if there are any particular conclusions from this review. I offer a number. First, that policy analyst and policy maker alike concluded that programs targeted for the poor prove to be poor programs. They are programs which, when the push is on for budgetary cuts, they become the large targets. Howard Newman said this to us in 1974 when we were working on the task force for health insurance here in New York, and it certainly is the view expressed

in *Health and the War on Poverty* by Karen Davis and Cathy Coen.[2] The greatest recognition that developed in the entire field of health policy during the 15 years was that all actions in the health care system are interconnected, and that policy makers ignore the interconnection at their peril.

Second, that everybody knew this to begin with. Only the newcomers came to see it. Certainly, the concept of a system approach was inherent in the famous Dawson Report back in England about 60 years ago.[3] It was clearly evident in the Report of the Committee on the Costs of Medical Care.[4] It was in the Beveridge Report.[5] The people who came to see it for the first time were largely young economists who began to move into the field and expressed interest in equitable distribution of resources as well as application of classical economic theories.

Third, much of the current new federalism was already there even in the 1960s. After all, what was Model Cities except an effort by the Johnson administration to bring together a variety of service programs that impinged upon individual clients in such a fragmented way that effectiveness was reduced and the complexity of the problem increased for local government? The phrase today is New Federalism; but under Johnson it was Creative Federalism. Block grants are not so new. The criticism of multiple federal programs was already so strong under Lyndon Johnson that it found legislative expression not only in the Model Cities law but in the Partnerships for Health Act.

Fourth, in the evolution of federal health policy economists came to dominate. We no longer talked about doctors. We no longer talked about nurses and hospitals. We began to talk about providers. We began to talk about the health care industry. We began to talk about the percentage of the gross national product and so on. It was inevitable that economists would apply to the health area economic concepts, especially of the classical type, which emphasize efficiency and minimize equity.

But here too one would have to say that although economists brought in the idea of competition and the idea of prevention, there is nothing new about these ideas. They go all the way back to Adam Smith and Benjamin Franklin, who coined the phrase "An ounce of prevention is worth a pound of cure." The problem is that we either do not know how to prevent or we do not know how to compel changes in lifestyle and personal behavior.

Fifth, much of this happened as the liberal became so beguiled by economic growth that he decided, contrary to all the teachings of political science and economics, that he did not have to choose. The 1960s and 1970s was the age of special-interest liberalism. We denigrated government and the public service to the point where we regarded them as just other special interests instead of the

essential framework for the process of choice and effective decisions in the public interest. It is very easy to be smart when there is a lot of money, but it is not easy to be smart when money is tight, especially when there is no solid political framework for choice.

Sixth, I suggest that in 1965 and early in subsequent years the liberal absolutely refused to accept the obvious outcome of the passage of Medicare and Medicaid, that is, that in time economic growth coupled with expansion of third party insurance would so mortgage the federal budget that public health policy would shift from concern for access to concern for costs. It can no longer be ignored that somewhere in the order of 10 to 12% of the federal budget is made up of programs for health care, either generally in the health field or for veterans and the military. How can one ignore that now more than one third of the federal budget is financed by regressive employment and social insurance taxes?

In the last analysis, the liberal took the same point of view as the conservative, namely, that health is a privately-oriented system. However, in dealing with privately-oriented systems, government must take some stand with respect to liberty if what it is trying to do is to achieve equality. The conservative did not want to impose the restrictions upon liberty. The liberal thought he could get equity without imposing the restrictions.

Seventh, another seeming paradox is the assumption that federal policy in 1965 was consciously designed to assure access to care and to make it available, affordable, and acceptable. For example, I recently read

> When the Great Society health programs began, the Department of HEW presented a plan to pursue a balanced policy for developing the delivery of health care for the poor and for its financing. Medicaid was to pay for a broad range of health services for the poor on welfare. Medicare was to assist the aged in meeting the cost of health care bills. Balancing these programs with approximately equal budgetary outlays were to be comprehensive health centers established in low income underserved areas.[6]

Policy is not always that rational. As somebody who was present at the creation, I must say that if the Department of Health, Education and Welfare did have a grand design, it was probably to get as many pieces of legislation on the books as possible, with the idea that eventually matters could be sorted out. It actually had no responsibility for the poor. If it had, we would never have needed the Office of Economic Opportunity. Transformation of the Old Bureau of Community Health Services from a public health to a medical care approach was a major achievement by a handful of young rebels.

In the health field, the Office of Economic Opportunity had authority only for demonstrations, and its authority was limited to about 50 neighborhood health centers. Staff papers that advanced the idea of from 1,000 to 3,000 neighbor-

hood health centers never achieved top policy sanction. Medicaid itself was an accident developed by Wilbur Mills. The Medicaid and Medicare legislation clearly carried proscriptions against interference by the federal government with the practice of medicine. Contrary to what some of us like now to believe, Medicare and Medicaid were never designed to do anything more than pay medical care bills and thus to deal only with the financial barrier to access. Had they been otherwise designed, I doubt that they could have been passed. The evolution of federal policy to deal with other barriers to access was very slow. In essence, the government relied upon the support of manpower and other resources to permit the health care system itself to overcome other barriers. It took a long time to tie comprehensive health planning to capital purchases under Medicare.

Eighth, although Congress enacted an incredible variety of legislation from 1965 to 1980, gestation had started long before 1965. For example, planning and regionalization, of which so much was made in 1974 legislation providing for health systems agencies, were all there in the studies for Hill-Burton made during the 1940s. Financing of care for the poor, which finally flowered in the Medicaid legislation, was already present in the 1935 social security debates. Children and youth projects and the maternity and infant care projects passed in 1965 were under way in World War II health programs. What was new was a total systems approach that linked investment to operations, financing to delivery, and so on. And it is this systems approach that began to emerge during the late 1960s and the 1970s.

I suppose that all policy makers know instinctively that to assure access to care, to make it reasonably available and affordable, political action must do what de Tocqueville saw in 1831 was necessary. The struggle to assure access to health care is the struggle between liberty and equality. America, like all democracies, has prided itself on equality of conditions, but it is equally proud of its character as a nation of free men and women. Among those freedoms are the freedom to choose one's doctor, to choose one's patients, to develop one's own specialty career, to work where one wants to, to help build or not build a hospital, and in general to be free of government restraints. By the late 1960s all the system deficiencies in health were quite evident, but it was crystal clear that costs would skyrocket.

My final conclusion is that perhaps the greatest lesson of the period from 1965 to 1980 is that it has shown much of the emptiness of the doctrine of pluralism. Pluralism has come to mean a system of government where everybody is in charge and nobody is in charge. Conservatives at least have faced up to the

consequences of the pluralistic form of society, where the current view is that government becomes no more than just another special interest at the bargaining table. I ask whether a government so hesitant about its legitimacy must not collapse when its power to give orders to the special interests who bargain is challenged, as is so often the case today.

Many people who pay lip service to pluralism are not aware of its complications. The fact is that we do live in a zero sum society, and the less economic growth and the less prosperity we have the more we are characterized as such a society. Equality and freedom are both good ends but one can rarely have more of one without surrendering some of the other. This is a very dispiriting thought to progressives, who prefer to believe that the goal which they now like is not incompatible with all the other goals they like. And so it has been with respect to the goal of access to care. It has always been impossible to have a successful goal with respect to access to care without at the same time doing something about the costs of medical care. Conservatives have had the progressives as their allies in refusing to act on costs. It is true that access, quality, and costs are trade-offs, and liberals have been simply unwilling from the outset, starting in 1965 if you will, to consider the implications of all those trade-offs. There really must be no equivocation, and it should be frankly admitted that liberty is being curtailed if we have a good cause for equality. Apparently there is a good cause for equality, but we seem to have lost sight of it along the way.

REFERENCES

1. Bush, V.: Science: *The Endless Frontier*. Washington, D.C., Govt. Print. Off., 1945. Reprinted by National Science Foundation, 1960.
2. Davis, K. and Schoen, C.: *Health and the War on Poverty*. Washington, D.C., The Brookings Inst., 1978.
3. Ministry of Health, Consultative Council on Medical and Allied Services (Lord Dawson Report): Interim Report on the Future Provision of Medical and Allied Services. Cmd. 603. London, 1920.
4. The Committee on the Costs of Medical Care., The Final Report: *Medical Care for the American People*. Chicago, University of Chicago Press, 1932 (reprinted in 1970 by the U.S. Department of Health, Education and Welfare).
5. Beveridge, Sir W.: *Social Insurance and Allied Services*. New York, MacMillan, 1942.
6. Davis and Schoen, op. cit., p. 213.